Questions & Answers

House Bill 2541

Q. What does donor complication rate data show across the American Red Cross system? Is there a difference in safety from one region to the next?
A. California has a state regulation requiring a registered nurse at each blood drive to oversee donor eligibility and manage donor reaction management.

For major donor complications based on the Red Cross Hemovigilance Program for FY13, the Red Cross Southern California Blood Services Region has a rate of 20 per 10,000 donations. The Northern California Blood Services Region has a rate of 25 per 10,000 donations. The Pacific Northwest Blood Services Region has a rate of 22 per 10,000 donations. The range for the national Red Cross system is from 10 per 10,000 donations to 25 per 10,000 donations. In terms of quality when defined as major donor complications, there is no evidence that the presence of a registered nurse at the blood drive results in fewer major donor complications.

The bar chart entitled: *Donor Complications Documented on a DCIR CY2013* displays every Red Cross region across the country, including Puerto Rico. The light blue bar atop the data represents minor complications. Major complications consist of a variety of situations – including instances when a donor needs to stay at a blood drive for at least 30 minutes after making a blood donation, even if only feeling lightheaded. Rather than ask staff to determine whether or not to report a complication or post-donation reaction, the Red Cross provides the guidance to report all and then classify as major those that take 30 minutes or more to resolve.

Q. The Oregon Nurses Association (ONA) claims that there is a high inventory of donated blood. Is this true? If not, how will House Bill 2541 affect inventory?
A. Inventory levels fluctuate, but the Red Cross typically carries about five days of inventory (just two days for platelets and O negative red blood cells). If mandated to have nurses on all blood drives, the Red Cross could be forced to cancel up to 10 percent of its blood drives when nurses are unavailable on a given day for a given drive. This is particularly challenging in the rural areas where there is not an adequate level of nursing staff in the region.

The implications could be severe for hospitals counting on availability of platelets and O negative red blood cells. Transfusions could be delayed and the health of patients could be compromised if these blood products are not available.

The Red Cross has a national network that allows us to move blood where it is needed, when it is needed. House Bill 2541 would require the Red Cross to leverage collections from other states to supplement inventory and offset limitations placed on local collections.

When blood collectors cancel drives, it leaves all other staff and supplies assigned for those drives without a place to go for the day. Those staff members lose the opportunity to earn wages, and the blood centers are faced with significant costs incurred for canceled operations. Those costs can amount to several million dollars over the course of a year.

Q. What does the training entail for Red Cross collections technicians that make them just as capable as nurses?
A. All collections staff members – regardless of whether or not they are nurses – must be trained and demonstrate full competency of each task before being released to perform that task.

The training for all staff includes:

- Drive setup and function check of equipment and supplies
- Registration and qualification of donors, which includes physical exam and health history
- Post-collection processing of the blood
- Donor complication management
- Managing suspect products and problem identification/reporting

Staff members who perform automated collection (apheresis) procedures receive additional training. Again, successful completion of the training program with demonstrated competency is mandatory.

All staff training includes both classroom and on-the-job instruction. In addition to annual reviews, periodic assessments are conducted throughout each year to ensure every staff member maintains competency.

Q. Why doesn't the Red Cross employ temporary nurses?
A. Collecting blood for transfusion is not considered a healthcare procedure, but rather a manufacturing procedure. This is because a prescribed pharmaceutical product is created from whole blood given from volunteer donors.

The manufacturing of pharmaceuticals is regulated by the U.S. Food and Drug Administration (FDA). Anyone participating in the regulated aspects of this process must be specifically trained in all "current Good Manufacturing Practices" outlined in the U.S. Code of Federal Regulations and the procedures of the specific blood bank. There is no license or degree – whether physician, nurse, or medical technologist – that circumvents this requirement.

All Red Cross collections staff must complete an extensive training program to meet FDA requirements and our own high standards of competency. Temporary nurses would not be able to complete the comprehensive training, or they would not stay with the Red Cross long enough for this to be a fiscally responsible option.

Q. How many incidents has the Red Cross recorded that required a nurse onsite?
A. The Red Cross has not recorded any incidents that specifically require a nurse's presence to manage. Our robust training, standard operating procedures (SOPs) and support resources provide the infrastructure necessary to handle all processes and situations associated with blood donation. This infrastructure includes trained collection technicians and supervisors on all drives, an electronic binder for reference to all SOPs, access to medical directors and the Red Cross Donor and Client Support Center (DCSC) on a 24-hours-a-day, seven-days-a-week basis, and established SOPs and protocols for addressing donor complications – including an escalation process that includes calling emergency medical services (911) when necessary.

Q. Ninety percent of Red Cross blood drives in Oregon have a nurse present. Why are nurses not present at the other 10 percent?
A. The Red Cross makes every effort to schedule a nurse to attend each Oregon blood drive. However, several factors contribute to our inability to staff 100 percent of drives with nurses, including:

- Staff vacancies
- Staff sick-calls
- Protected leave under the Oregon Family Leave Act (OFLA) and the Family Medical Leave Act (FMLA)
- Quality of life: Nurses are not happy about last-minute schedule changes when a colleague calls in sick. A mandate would lead to greater unpredictability about their schedules, more nurse dissatisfaction and greater turnover.

Three factors in particular pose particular challenges with having at least one nurse present at every blood drive:

- **Vacant positions**: The turnover rate for Red Cross nurses in these positions was 175 percent last year. Many nurses tell us that the work they do at blood drives is not "traditional nursing," and is not what they went to school to learn. Keeping nurses interested in working at blood drives is challenging.
- **Sick calls**: On average, between four and five nurses call in sick each weekday, when most blood drives are scheduled. In fact, the 40 nurses who are employed in the Red Cross Pacific Northwest Blood Services Region at any one time, on average, logged 476 days of sick time in 2014. Most of that time was unplanned.
- **Geography**: The region collects blood in a number of rural communities – from the Oregon coast to as far east as Burns and Lakeview. A nurse who is suddenly unable to travel to one of these cities due to unplanned absence is virtually impossible to replace on short notice. The Red Cross makes every attempt to replace the nurse, but this is particularly challenging when the team is headed out of town on a multi-day blood drive, moving from one community to the next.

Under the ONA/Red Cross Bargaining Unit Agreement, the Red Cross makes a best effort to schedule a licensed nurse at every blood drive when posting the schedule. The scheduled nurse percentage is much higher than the number of nurses who actually work as scheduled, due to absences for a variety of reasons. It is important to note that this agreement includes blood drives originating from Red Cross offices in Portland, Salem, Roseburg, Medford, Klamath Falls and Bend, Oregon, as well as Vancouver, Washington. In these areas, we conducted 5,412 blood drives in 2014 and staffed more than 90 percent with a nurse.

Blood drives originating from other Red Cross sites are out of scope of this requirement and currently operate without an Oregon licensed nurse in every case. Those sites include Richland and Yakima, Washington, and Boise and Lewiston, Idaho. In those areas, we held 144 drives in Oregon in 2014. House Bill 2541 would either result in adding full time Oregon-licensed nurses to teams in these four cities or no longer collecting blood in Oregon with them – given the difficulty and expense of hiring Oregon-licensed nurses to work predominately in Washington and Idaho.

Q. What standards and guidelines does the Red Cross follow regarding medical professionals at blood drives?
A. There is a staffing matrix in our electronic operating system (Hemasphere) that determines the number of staff and the roles they serve at blood drives based on the number of expected donations. The matrix is derived from the Standardized Drive Guidance on staffing blood drives via lean engineering.

In regions that do not have a requirement for a nurse at each blood drive, all staff can be unlicensed with various levels of education, experience, etc., as long as they meet the job description requirements for their role and have gone through the applicable regulated training for their position. In California and Oregon, additional modeling intelligence is in place to ensure nurses are scheduled on drives according to state law or collective bargaining agreement requirements.

Q. What do regulatory agencies look at with regard to donor reactions and what is the audit process?
A. All blood banks, including the Red Cross, are subject to regular inspections by the Food and Drug Administration (FDA) and the AABB (formerly known as the American Association of Blood Banks). In addition, the Red Cross has its own internal auditors for all processes and procedures associated with blood collection – including donor complication management. Record reviews during these audits include donor adverse reaction complaints and reports, and the results of all associated investigations and follow-up.

Q. What is the cost of having a nurse onsite at all Red Cross blood drives in Oregon?
A. In the Pacific Northwest Region, a nurse earns $10 to $15 more per hour than a collection technician who is adequately trained to perform the tasks associated with the collection of blood ($25 to $30 an hour versus $15 an hour on average). This means it costs the Red Cross about $25,000 more per year for each nurse. This equates to roughly $1 million in higher costs in Oregon for the Red Cross (or approximately $5 per unit of blood collected) based on current activity levels.

Q. There is a law in place in New Jersey that is similar to House Bill 2541. What does that law mandate and how has it affected blood collections in the state?
A. New Jersey state law requires the presence of a licensed nurse when collecting blood at a high school or from any group predominantly made up of high school-aged donors. The Red Cross Penn-Jersey Blood Services Region has seen an increase in overtime due to the legislation, but no substantial impact to operations. However, the legislation affects only a small portion of blood drives held in the state.

Q. Why does the Red Cross contend that it is not trying to eliminate nurses, while also saying they are working below their certification level and are expensive to employ?
A. The Red Cross is not trying to eliminate nurses. In fact, we entered into a collective bargaining agreement with the Oregon Nurses Association which states that the Red Cross will “make every reasonable effort” to staff licensed nurses at blood drives held in the state of Oregon. The Red Cross continues to comply with that collective bargaining agreement, but also acknowledges the common feedback it receives from staff nurses that they are generally not doing nursing work.

Q. Where are nurses needed at Red Cross blood drives?
A. Every state has nurse practice acts that provide guidance for when a nurse must perform a particular task. The Red Cross follows the existing nurse practice act in Oregon, and utilizes nurses in clinical settings with the patient population (as compared to the donor population) for a variety of patient needs (therapeutic collections) where the extensive training and skills of our nurses can best be utilized. In contrast, those skills are not needed when performing procedures on healthy blood donors who are required to meet certain health requirements in order to donate.

Q. If House Bill 2541 passes, what will be the impact to non-licensed collections staff with the Red Cross in the Pacific Northwest Region?
A. The addition of more nursing positions will directly lead to a reduction in the number of non-licensed collections technicians currently employed by the Red Cross. Additionally, non-licensed blood collections personnel employed by the Red Cross in Oregon and Washington are working under a collective bargaining agreement with the Teamsters. These employees are our lower paid employees who start at approximately $12.50 per hour. The result of House Bill 2541 will be that these employees will receive a reduction in work hours. The region will likely be forced to reduce the number of positions as costs increase due to the fact that the bill will force a reduction in Red Cross blood collections within Oregon. The reduction in work hours will take place each time a nurse is unavailable for a shift and the Red Cross is unable to assign a nurse to that blood drive, requiring cancellation. The other employees will be sent home when not needed at other blood drives in the vicinity.

Q. How many blood drives did the Red Cross conduct in Oregon in 2014?
A. The Red Cross collected 167,494 units of blood at 5,556 blood drives held in Oregon in 2014. The drives were staffed by teams based out of the following areas:

- Portland - 2,628 drives
- Salem and Southern Oregon – 1,089 drives
- Bend/Klamath Falls – 891 drives
- Roseburg/Medford – 804 drives
- Washington – 100 drives
- Idaho – 44 drives

Q. Is the Oregon Nurses Association correct when it claims that the Red Cross is moving away from using nurses at blood drives, thereby making blood donation less safe?
A. This claim is incorrect

Donor complication rates are low in every state, and range from 10 per 10,000 donations to 25 per 10,000 donations. In fact, donor complication rates in California and the Pacific Northwest, where the Red Cross currently deploys licensed staff on blood drives, are near the upper end of that range.

There has been no meaningful trend change when unlicensed staff members perform all tasks at blood drives. Overall, donor safety levels have remained very high throughout the years.

Due to better patient blood management programs and advances in technology, the blood collection industry is facing a decline in utilization of blood products (20 to 30 percent). This decline is affecting all organizations, and forcing job eliminations across all functions in order to ensure that staffing levels meet current collection needs.

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